

SCHABERG DERMATOLOGY
(618-288-9450)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Thank you for choosing Schaberg Dermatology for your health care needs.

We are required by law to provide you with a copy of our Notice of Privacy Practices. To ensure that our records are accurate, please sign this form and return it to our receptionist to acknowledge that you have been provided with a copy of our Notice.

Signature of Patient (or Legal Representative)

Date

Signature of Staff Member

Title

Date

**CONSENT FOR RELEASE OF INFORMATION TO
DESIGNATED FAMILY MEMBER OR CAREGIVER**

The undersigned consents to Schaberg Dermatology releasing his/her medical information to:

Name to Receive Info & Relationship to Patient

Name to Receive Info & Relationship to Patient

Name to Receive Info & Relationship to Patient

This consent remains in effect for a one (1) year period (as signed by the designee.) This form must be resigned at the year's expiration. This consent may be revoked at any time upon written request.

Signed _____

Date _____

Comments:

